
# MEDI-CAL PROGRAM HIGHLIGHTS
# CALENDAR YEAR 1996

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## THE MEDI-CAL PROGRAM

## A BRIEF SUMMARY OF MAJOR EVENTS

## INTRODUCTION

The California Medical Assistance Program (Medi-Cal) was established pursuant to Chapter 4, Statutes of 1965, by the Second Extraordinary Session of the California Legislature. The program was enacted to take advantage of federal funds made available by the 1965 Title XIX amendments to the Social Security Act. The stated purpose was to provide "basic and extended health care and related remedial or preventive services to recipients of public assistance and to medically needy aged and other persons, including such related social services as are necessary".

A further intent of the program was that the medical care should be mainstream. Mainstream was defined as comparable to care purchased out of pocket or through private insurance. Prior to Medi-Cal, many public assistance and medically needy persons were forced to rely on charitable institutions, especially county hospitals. These hospitals were generally prohibited by law from accepting paying patients.

The new program also required certain basic services be made available to all beneficiaries. Under the medical programs replaced by Medi-Cal, it was possible to deny medical services to adults in aid to needy children cases, but provide them to other adult beneficiaries.

The new federal law required the State to work towards general improvement in the amount and quality of medical care provided to beneficiaries, improvements in medical social services, and improvements in the organization and delivery of medical care to eligible beneficiaries. The State was also required to work toward extending Medi-Cal coverage to medically indigent persons (noncategorically linked persons 21-64 years old) by July 1, 1977; this was subsequently repealed by the Social Security Amendments of 1972.

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## ADMINISTRATIVE STRUCTURE

The Office of Health Care Services, Health and welfare Agency, was designated as the agency to coordinate and supervise the activities of the various State departments involved in the Medi-Cal program. Four State departments were directly involved in the Medi-Cal program: Social Welfare, Public Health, Mental Hygiene, and Rehabilitation. The Office was also concerned with policy determination, fiscal and management control, program planning and review, training assistance, and federal program relations.

The sum of $546,000 was appropriated by the Legislation to be used for developmental costs. Planning was centered in the Health and Welfare Agency Administrator's Office, with detail work assigned to the Departments of Mental Hygiene, Public Health, and Social Welfare. Delay resulted at the State level because of late receipt of materials from the Federal Government about Title XIX of the Social Security Act. Few authorized planning positions were filled because of this delay, so substantial work was done by existing staff on an emergency basis. Only about half ($267,500) of the planning money was spent.

The Department of Social Welfare's primary concern was supervision of county operations, especially the determination of eligibility for cash benefits and/or medical care. Public Health was concerned with certification of facilities and certain providers under the program. Mental Hygiene's relation with the Program had to do with eligibility of patients in mental hospitals, while Rehabilitation's concern was rehabilitation of those Medi-Cal beneficiaries who could benefit from training.

In order to meet the March 1, 1966 federal implementation date, the Program contracted with three fiscal intermediaries: California Physician's Services (Blue Shield), the Hospital Service of California (Blue Cross North), and the Hospital Service of Southern California (Blue Cross South). The original contract was to expire December 31, 1966, with provision for a month to month extension. The intention was to extend the contract monthly until a prepayment plan could be implemented, or if prepayment was not feasible, until the State could assume operation of the fiscal intermediary activities. In the Special Addendum to the California State Budget of Fiscal Year 1966-67, it was "anticipated that the fiscal intermediary operation (would) be replaced either by a prepayment system or by State operation no later than July 1, 1976". Neither came to pass, although 227,000 Medi-Cal eligibles were under prepayment by June 1974 and certain fiscal intermediary operations were assumed by groups other than the original Blue Shield-Blue Cross organizations.

The Office of Health Care Services administered the Medi-Cal program until September 14, 1968, when the Department of Health Care Services came into being. The Department was created during a reorganization of the Executive Branch of the State Government. The new Department was undoubtedly an acknowledgement of the significance and magnitude of the Medi-Cal program. The bill paying aspect of the Program continued to be handled through fiscal intermediaries.

In 1973, as part of a plan to centralize administration of programs dealing with health, the Department of Health Care Services was absorbed into the newly established Department of Health. The Medi-Cal program was one of the major divisions of the Department of Health.

Subsequently, in July 1978, the Department of Health was reorganized into five separate departments, one of which is the Department of Health Services. Administration of the Medi-Cal program is one of the Department's major responsibilities.

## BENEFITS AND ELIGIBLE PERSONS

The hastily established Medi-Cal program offered one of the most comprehensive programs of medical assistance imaginable to 1.3 million eligible beneficiaries. Previously, public assistance recipients received care under either the Public Assistance Medical Care (PAMC) program or the Medical Assistance for the Aged (MAA). The latter program was for aged persons in need of inpatient extended care. The PAMC program, which was the main medical program, had a number of significant exclusions. Major exclusions were that AFDC adults were not covered except for emergency dental care and outpatient rehabilitation services (services virtually nonexistent). Acute hospital care was only provided for the bind; other beneficiaries had to use the county hospital. Medically needy persons, except certain former MAA beneficiaries, were also excluded from coverage.

Medi-Cal, on the other hand, offered an almost unlimited range of medical services to public assistance recipients, such as inpatient and outpatient hospital services, physician services, laboratory and x-ray, nursing home care, prescription drugs, and ambulance services. The Program covered hearing aids and medical care devices, and services usually not generally available under any insurance scheme, such as chiropractic, podiatry, dentistry, and home health care. The Program also covered organized outpatient mental health programs, birth control devices and drugs, and rehabilitation center services. Some control was placed on the drug program through a drug formulary and prior authorization for certain services and supplies. The controls, however, were nominal.

From the beginning of the Program through September 30, 1971, a major provider of medical services to the poor continued to be county hospitals.

Certain medically needy persons were extended coverage but not on such an elaborate scale. These were persons with income and/or property in excess of the public assistance limitations. These were identified as "Group II eligibles", as opposed to the Group I eligibles who received all the benefits outlined above. Some had a liability amount to pay before Medi-Cal would pay. They received physician and hospital care, nursing home care, laboratory and x-ray services, and prescription drugs. Other outpatient services were available, but only during 90 days following

discharge from inpatient care. The care had to be ordered by a physician, dentist, or podiatrist under conditions relating to the cause of inpatient care. Although California residence was necessary, no period of residence in California was required to receive medical assistance. There was, however, a durational residence requirement for a welfare cash grant.

The full schedule of benefits available to Group I eligibles was extended to all Medi-Cal eligibles effective August 1, 1970. At the same time, more restrictive eligibility standards were put into place for medically needy (Group II) eligibles.

The Medically indigent became eligible for Medi-Cal benefits with the implementation of the Medi-Cal Reform Act of 1971, effective October 1, 1971. The subsequent passage of AB 799 and SB 2012 (Statutes of 1982) transferred responsibility for most medically indigent adults (ages 21-64 years) from the State to the counties effective January 1, 1983. This was in response to a severe fiscal crisis being faced by the State Government.

Medically indigent children (under 21 years old), indigent refugees during their first 18 months of U.S. residence, and indigent adult women with confirmed pregnancies remained eligible for the full scope of Medi-Cal benefits. Medically indigent adults residing in long-term care facilities remained eligible for all Medi-Cal benefits except acute care hospital inpatient services.

## THE PROVIDERS

All providers or practitioners who meet the qualifications for licensure or for practicing in the State may provide care or service for Medi-Cal beneficiaries unless suspended from participation. Providers are licensed or certified by various boards or bodies and present evidence to the Department of Health Services in order to be certified and listed on the "master provider list". Out-of-state providers may also service Medi-Cal beneficiaries to the extent the provider is licensed in the other state and the service is a Medi-Cal covered service.

Counties were provided the option of either (1) billing Medi-Cal for services to Medi-Cal eligibles and paying for services to non-Medi-Cal eligibles who were indigent or (2) of increasing their county's contribution to the Health Care Deposit Fund and billing Medi-Cal for care provided to all indigents. This was known as the County Option.

## NOTE

This report is for informational purposes only and does not purport to be, or attempt to give, legal interpretation of rules, regulations, and laws pertaining to the Medi-cal program. Questions and comments may be directed to Mary Cline, Medical Care Statistics Section (916) 657-2794.

## HIGHLIGHTS OF 1996 PROGRAM CHANGES

The following discusses the major changes in Medi-Cal and related programs during Calendar Year 1996.

New County Health System: Santa Cruz County Health Options (SCCHO), January 1, 1996

A new County Health Initiative was implemented for Santa Cruz County Medi-Cal recipients. Santa Cruz County Health Options (SCCHO) is a Medi-Cal county wide program administered by the Santa Cruz Managed Medical Care Commission.

Beginning January 1, 1996, SCCHO will serve all Medi-Cal eligible and Medicare/Medi-cal eligible recipients who have ID numbers with County Code 44 (Santa Cruz County) and one of the following aid codes.

| Category | Aid Codes |
|---|---|
| Adult | 81, 86, 87 |
| Aged | 10, 14, 16, 17, 18 |
| Child | 03, 04, 45, 82, 83, 4C, 4K, 5K |
| Disabled | 20, 24, 26, 27, 28, 36, 60, 64, 65, 66, 67, 68, 6A, 6C |
| Family | 01, 02, 08, 30, 32, 33, 34, 35, 37, 38, 39, 40, 42, 54, 59, 3A, 3C,3P,3R |
| Long Term Care | 13, 23, 53, 63 |

Medi-Cal Managed Care Program – Two-Plan Model, January 1996

The Department of Health Services (DHS) began implementing the Medi-Cal "Two-Plan Model" managed care program in January 1996. Operating under a Federal Medicaid "freedom of choice" waiver, Two-Plan Model contractors now provide or are preparing to provide medical services to nearly all Medi-Cal recipients in 12 California Counties (Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare). Eight counties had at least one plan operational by the end of 1996, with Alameda and Kern being fully implemented (both Local Initiative and Commercial Plan were operational).

In each of the 12 counties, DHS has contracted with two managed care plans to render Medi-Cal services. One contract, awarded through competitive bidding, is with a commercial health plan. The other contract is with a local initiative – a publicly sponsored health plan cooperatively developed by local government, clinics, hospital, physicians, and other providers – that historically served the Medi-Cal population in that county. Medi-Cal services not covered by the health plans will continue to be available through the Medi-Cal Fee-For Service program.

The mandatory enrollees (those who must make a choice between the Local Initiative and the Commercial Plan) represent the shift from Fee-For-Service to Managed Care for Public Assistance – Families, Medically Needy – Families, and Medically Indigent Children. The voluntary enrollees (those who may choose to enroll) are those in Public Assistance: Aged, Blind/Disabled; Medically Needy: Aged, Blind/Disabled; AFDC-Foster Care; and Medically Indigent-Adult.

Expanded Tuberculosis Services, March 1, 1996

The Medi-Cal Tuberculosis (TB) program implements sections of OBRA 93 which provides Federal Financial Participation (FFP) for outpatient TB services to infected individuals (non-Medi-Cal). Health Care Financing Administration (HCFA) has determined that Direct Observation Therapy (DOT) must be billed as a direct service rather than as a Medi-Cal Administrative Activity. This policy change adds DOT as a Medi-Cal funded service for "all" Medi-Cal eligibles who are infected with TB.

Expanded Medical Case Management, April 1, 1996

Medical Case Management is expanding into additional hospitals, specifically county hospitals, to provide alternative outpatient services for hospital inpatients with follow-up to ensure continuity of care postdischarge. The program is also expanding to cover patients who are less chronically/catastrophically ill than is in the current caseload.

Transitional Inpatient Care (TC) Program, April 1, 1996

Effective April 1, 1996, the Department implemented the Medi-Cal Transitional Inpatient Care (TC) Services program for hospital inpatients who are clinically stable and have medical and/or rehabilitative care needs of short-term durations which can be provided at a lower level of care in either a qualified nursing facility or hospital bed.

Antidepressant Drugs, May 1, 1996

On May 1, 1996, newer and safer antidepressant drugs were added to the Medi-Cal List of Contract Drugs.

Medicaid Demonstration Project, May 1, 1996

The Medicaid demonstration project is designed to address the current fiscal crisis at the county level by helping to stabilize county health care systems, and to foster a unique restructuring process that is responsive to the needs of local communities within the evolving health care environment.

Gamma v. Belshé, July 1, 1996

A lawsuit brought in federal court, involves the issue of whether Medi-Cal procedures for determining maintenance need levels and deeming of income from responsible relatives in households affected by the earlier Sneede v. Kizer case violate federal law. The court ruled on November 16, 1995, that the Department must allow to parents to meet their own financial needs before allocating any of their income to their children.

The court approved the Department's plan for implementing this change.

Medicare Outpatient Crossover Claims, September 1996

As a result of lawsuits filed by the California Medical Association and the California Ambulance Association, Medicare coinsurance and deductibles for outpatient services are to be paid for Qualified Medicare Beneficiaries (QMBs) even though combined Medicare/Medi-Cal payments to the provider will exceed Medi-Cal allowable costs.

Federal Medical Assistance Percentage (FMAP) Changes, October 1, 1996

Each year the Federal Government calculates the Federal Medical Assistance Percentage (FMAP) which determines the Federal sharing ratio used for medical assistance payments for each state. The calculation is based on a complex formula involving per capita income in each state in relation to total U.S. per capita income. The FMAP has a minimum of 50% and a maximum of 83%. California had been at the minimum 50% since Medicaid began.

The FMAP for California which applies to cash payments for the Federal Fiscal Year (FFY) beginning October 1996 is 50.23%. The FMAP for the FFY beginning October 1997 has been calculated to be 51.23%.

Minimum Wage Increase, October 1996

The new minimum wage changes, including both Federal and State changes, result in the following four new levels above the previous rate of $4.25 per hour:

1. $4.74/hour as of October 1, 1996 (federal)
2. $5.00/hour as of March 1, 1996 (state)
3. $5.15/hour as of September 1, 1997 (federal)
4. $5.75/hour as of March 1, 1998 (state)

Airport Residency Review, November 1996

Audits and Investigations currently has a joint project with Immigration and Naturalization Service (INS) at the Los Angeles and San Francisco International airports. This program identifies those entering California who are currently receiving or previously received Medi-Cal benefits. Payment made on behalf of the recipient are verified and the opportunity for repayment is provided to the “entrant”. INS inspectors determine entry status at the international terminal and may grant or deny entry based on their evaluation of the circumstances. If entry is denied, the Medi-Cal eligibility is terminated due to lack of California residency.

To implement this project, three limited-term investigators were hired in July 1996 to handle arrivals at these two airports.